Innovative Approach to Engage Older Adults with Technology

Peter Hoang, Colin R.J. Whaley

Geriatric Inclusive Art as a Promoter of Wellbeing: A Pilot Program

Kacper Niburski, Uyen Doan, Dr. Oliver Beauchet
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## Letter from the NGIG Co-chairs

Dear readers,

We are excited to share with you the 6th Annual National Geriatrics Interest Group (NGIG) Publication. Medical students from across Canada have submitted inspiring articles, captivating artwork and photographs that highlight this year’s theme: “Healthy Aging: Innovations and Strategies in Geriatric Medicine and Research.” We are thrilled to publish this compilation of writing, illustrating, and creative contributions that showcase the talent and efforts of medical students. We hope you enjoy and get inspired by reading this publication!

This publication along with our many initiatives would not have been possible without the help of many individuals and organizations. We would like to thank the CGS for their continued support, Dr. Tricia Woo for her mentorship, and the Resident Geriatrics Interest Group (RGGi) for their commitment to collaboration with medical students. We would like to acknowledge the many enthusiastic members on the NGIG team that have contributed to the NGIG initiative during medical school, who have embraced our mission to improve the care of our geriatric population.

We are excited to share with you the 6th Annual National Geriatrics Interest Group (NGIG) Publication. Medical students from across Canada have submitted inspiring articles, captivating artwork and photographs that highlight this year’s theme: “Healthy Aging: Innovations and Strategies in Geriatric Medicine and Research.”

Sincerely,

Amanda Chen and Bonnie Cheung  
NGIG Co-Chairs 2017-2018
Newspublication, Volume 7, April 2018

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A Good Death in a Good Place: An Opportunity for Design

O

er the past few decades, the desire to enhance end-of-life care has become a globally relevant social concern. With Canada's 2016 legislation for Medical Assistance in Dying (MAiD), new questions about patient choice and end-of-life decision-making arise—not just in terms of how death occurs, but also where it may be situated.

A clear link between the quality of end-of-life and the location of death have been shown in numerous studies (1-3). Research has shown that family members favor home or hospice palliation over hospital or nursing home settings (4, 5). In 2011, a national study in the United States found that the bereaved family members of de-

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ments patients in nursing homes and hospitals reported a greater rate of “unmet needs” for symptom management, concerns with physical health, and family difficulty (6). However, in this context, families of patients with home hospice services reported higher satisfaction, fewer concerns with care, and fewer unmet needs (6).

Other research has similarly shown that while most terminal can-

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cer patients receive end-of-life care in an institutional setting, the vast majority would prefer to receive palliative care at home (7). In overview, there is evidence to suggest that—despite the limitations of home-based care—patients, families and healthcare providers generally believe medical settings to be under-equipped to meet the needs and expectations of dying persons.

Across cultures and societies, human beings exhibit behaviors, responses and values that link to physical spaces and material objects. Investigating these links reveals that appropriately designed spaces can benefit both individuals and society. What role can designers play within the current landscape of end-of-life care? First, as design critic Alice Rawsthorn suggests, design for the end-of-life can alter the current framing of and organizational controls around death and dying.

When well-designed technology can help improve our every living moment, why should it desert us in death? In theory, design could—and should—have a vital part to play in improving the quality of any aspect of daily life that is no longer fit for purpose, and death is no exception. [...] analyzing the strengths and weaknesses of present sys-

tems and rituals with an open mind, and applying grace, foresight, rigour, sensitivity and imagination to envisaging better outcomes could help us to die more humanely. (3)

Second, as a post anthropologist Janer Huynh at Parsons School of Design (USA), there are also pragmatic usability and foundational aesthetic factors to be considered in building physical care loca-

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tions. This includes “making the care experience feel less awful.

Because people aren’t working in a way that’s been consciously and empathically designed, there are many unintentional bad moments that add to the difficulty of the situation” (9). Both Rawsthorn and Huynh, however warn designers that there exists the risk of “crassly commercializing or commodifying death” (9). Dying is a sphere where “the interests of the government, religion, the law, capitalism and free will all converge, making it an unusually complex field” (8). Design for end-of-life care, therefore, requires us to venture into the field with sensitivity, humanity, and purpose.

Overall, one must recognize that spaces for the dying are also spaces populated by the living. Stephen Verderber, Professor of Architecture and Public Health at the University of Toronto (Can-
da), writes that human beings are pacified by spatial conditions implying security, privacy, intrinsic meaning and value. In times of sickness, feelings of uncertainty, isolation, powerlessness, alienation and depression affect the acceptance of matters pertaining to life and death, ultimately influencing the patient's outlooks, attitudes, and quality of death. He notes that the ability to accept existential questions about medical decision making, and contentment with health services, and experience a sense of control—are all directly manifested in the physical appearance and design of care spaces (10).

While design that celebrates, optimizes and sustains living condi-

tions is plentiful, relatively little design concerns itself with death and dying. As a result, even within care spaces, palliative zones are much less visible or consciously built than curative ones. Envisaging well-considered, physically comfortable, emotionally sensitive, aesthetic, and functional spaces can relieve stress and increase satisfaction with the quality care being received. Death—one of life’s most vulnerable and profound moments—falls directly within design’s ambit and registers an urgent call to designers today.


Breast cancer is the most common cancer among Canadian women, accounting for 26% of newly-diagnosed cancer cases (1). While incidence rates have remained stable over the past 30 years, breast cancer affects more Canadian women now than ever before owing to our growing and aging population (1). Indeed, the Canadian Cancer Society reports that as of 2016, nearly a third of new breast cancer diagnoses occur in women aged 69 years and older—a figure that stands to increase with time and underscores the need for advancements in geriatric oncology (1). With mortality rates at record lows (1), there has been greater emphasis on quality of life for breast cancer survivors. This includes the provision of patient-centred care that empowers patients to make informed decisions based on the full range of treatment options available to them. One such area where this is lacking is breast cancer reconstruction in older women diagnosed with cancers serious enough to warrant unilateral or bilateral mastectomies.

Between 2002 and 2012, the mean age of Canadian women receiving immediate breast reconstruction was 49 years versus 62 years for mastectomy-only patients (2). This disparity does not reflect the 20% Cancer Care Ontario guidelines, which explicitly state that age in itself should not be a contraindication for breast reconstruction surgery provided the patient is healthy (3). Nonetheless, many patients and healthcare professionals presume older women are more likely to experience complications with surgery. This cautious mindset, while surely well-intentioned, promotes a culture in which clinicians are reluctant to suggest surgery to their older patients, inadvertently depriving them of a viable option.

What options remain for those who forego breast reconstruction? Some women who were dramatically impacted by their cancer experience decide “going flat” is a fitting reflection of their post-mastectomy persona. Others choose to wear external prostheses, which have been described as hot, heavy, and irritating to post-mastectomy persona. Yet others choose to wear external prostheses, which have been described as hot, heavy, and irritating to post-mastectomy persona. Others choose to wear external prostheses, which have been described as hot, heavy, and irritating to post-mastectomy persona. Nonetheless, some women who were dramatically impacted by their cancer experience decide “going flat” is a fitting reflection of their post-mastectomy persona. Others choose to wear external prostheses, which have been described as hot, heavy, and irritating to post-mastectomy persona. However, what options remain for those who forego breast reconstruction? Some women who were dramatically impacted by their cancer experience decide “going flat” is a fitting reflection of their post-mastectomy persona. Others choose to wear external prostheses, which have been described as hot, heavy, and irritating to post-mastectomy persona. But the advantages of offering breast reconstruction to patients extend beyond aesthetics. One study found age alone does not significantly predict overall or mastectomy-related complications (4). Breast reconstruction, particularly the autologous type which uses patients’ own tissues from elsewhere in their body to recreate their breasts, bypasses these problems while providing women with a natural appearance. But the advantages of offering breast reconstruction to patients extend beyond aesthetics. One study reported better patient-reported outcomes related to mental health in older women who underwent breast reconstruction compared to previously reported in younger patients and age-matched patients in the general population (5). Another found just discussing breast reconstruction may have therapeutic value, as it “alleviated the trauma of mastectomy” for 39% of patients (6). However, given the association between perioperative complications and comorbidities, which tend to increase with age (7), breast surgeons’ reservations are not unfounded. While it may be tempting to conclude that older women are poorer candidates for breast reconstruction, it is important that clinicians do not allow age to confound each patient’s individual risk.

How do we overcome the barriers to offering breast reconstruction to older women? Thankfully, the road has partly been paved for us. Using progressive models such as Proactive Care of Elderly People Undergoing Surgery, which allows clinicians to better predict surgical risk in older patients, has been shown to improve perioperative outcomes and shorten hospital stays (8). Focused history-taking and physical examinations that include assessments of functional impairment, frailty, and mental status, all of which are especially useful for older patients, have also been used prospectively by many surgeons (9-12). These strategies clear the way for breast reconstruction procedures that are safe for healthy elders, as evidenced by a number of studies spanning two decades that have found age alone does not significantly predict overall or major complications (13-15). Moreover, there is evidence for patient satisfaction with the experience, with one study reporting that 70% of patients aged 60-77 years rated their outcome as “good or excellent” (16).

Agism is by no means the sole factor driving the undertreatment of older women with breast reconstruction surgery, but it appears to be playing a contributory role given the safety and outcomes associated with the procedures (13-15). Far more research is needed to discern what type of reconstruction is best suited for elders. But until then, women of all ages stand to benefit from at least being offered breast reconstruction as a treatment option.

References:

Alex and Michael are second-year LaTST medical students with a keen interest in improving health outcomes for older adults, particularly in relation to geriatric surgery. Stephi is a caregiver and an MA candidate in Critical Disability Studies at York University who is passionate about overcoming the systemic barriers impeding the wellbeing of elders with disabilities.
An Evolving Landscape in Geriatric Care: Why Health Professions Should Embrace Interprofessional Education

MICHAEL D. ELFASY AND ALEXANDER ADIBFAR
MD CANDIDATES, CLASS OF 2020, UNIVERSITY OF TORONTO

Canada is currently facing its biggest healthcare challenge to date: providing effective, affordable, and individualized care to its aging population. The medical advancements of the 20th century gave rise to an unprecedented increase in life expectancy, and we are now beginning to experience their long-term consequences as the baby boomer cohort transitions into late adulthood. From 2011 to 2016, our senior population (aged 65+ years) increased by 20%, with seniors now outnumbering children for the first time in our country’s history (1). Additionally, this five-year period saw the number of Canadians aged 85 years or more increase by 19.4%, a rate nearly four times greater than that of our overall population. These numbers are projected to grow substantially as the baby boomer cohort ages (2). This demographic shift is placing a substantial strain on our healthcare system. The medical advancements of the 20th century gave rise to an unprecedented increase in life expectancy, and we are now beginning to experience their long-term consequences as the baby boomer cohort transitions into late adulthood. From 2011 to 2016, our senior population (aged 65+ years) increased by 20%, with seniors now outnumbering children for the first time in our country’s history (1). Additionally, this five-year period saw the number of Canadians aged 85 years or more increase by 19.4%, a rate nearly four times greater than that of our overall population. These numbers are projected to grow substantially as the baby boomer cohort ages (2). This demographic shift is placing a substantial strain on our healthcare system.

The Acute Care for Elders (ACE) strategy is a leading model attempting to revolutionize the way we practice geriatric medicine by transitioning from a narrow, disease-centered paradigm to a holistic, interdisciplinary, person-centered approach. ACE harnesses the skills of different care providers including physicians of different specialties, nurses, physiotherapists, volunteers, social workers, pharmacists, and administrators. This collaborative approach tends to patients’ needs along the entire biopsychosocial spectrum and at every stage of care, from hospital admission to discharge and eventually home-based care. It has been successful on several fronts at Mount Sinai Hospital in Toronto, cutting average length of hospital stay by 28.3% and decreasing readmissions within 30 days by 13.4%, all while effectively reducing direct costs of care per patient by 22.7% and improving patient-reported satisfaction (4, 5).

While our healthcare system is adept at treating and managing acute, episodic conditions, it is less equipped to handle chronic, complex diseases. As 75-80% of Canadian seniors report having one or more chronic conditions, the demand for complex care is quickly outpacing the supply (3). This systemic flow causes many downstream sequela including inadequate community support, ineffective and harmful hospital admissions, and patient dissatisfaction, which collectively cost billions of dollars (4, 5). To combat these unsustainable realities, novel strategies focused primarily on interdisciplinary collaboration are restructuring the way geriatric care is delivered on a system-wide level across the country.

The next future requires greater interdisciplinary collaboration to optimize care for older adults. To meet these needs, schools for health professions in Canada are beginning to embrace interprofessional education (IPE) in their curricula (9). By cultivating the collegial spirit that has made programs like ACE a success, IPE holds the key to preparing the next generation of healthcare providers for the torrent of chronicity and complexity facing our healthcare system. As the next wave of care providers obtain these specific competencies, we are likely to move further away from the siloed professional education (IPE) framework and are achieving similar results (8).

Strategies like ACE are quickly becoming commonplace in Canada. ACE itself is being implemented in 18 hospitals nationwide with support from the Canadian Foundation for Healthcare Improvement and are achieving similar results (8).

The near future requires greater interdisciplinary collaboration to optimize care for older adults. To meet these needs, schools for health professions in Canada are beginning to embrace interprofessional education (IPE) in their curricula (9). By cultivating the collegial spirit that has made programs like ACE a success, IPE holds the key to preparing the next generation of healthcare providers for the torrent of chronicity and complexity facing our healthcare system. As the next wave of care providers obtain these specific competencies, we are likely to move further away from the siloed multidisciplinary systems of the past and move closer toward a comprehensive, interdisciplinary strategy for geriatric care in Canada. For IPE to have the greatest possible impact on students, it will be essential to include case-based teaching modalities of older patients who not only have complex needs but also stand to benefit the most from interprofessional care. This will provide a challenging opportunity for students of different disciplines to collaborate, clarify their individual roles, and work to integrate all aspects of patient care in a complex environment.

As standards of care evolve, so too should the education of future health professionals who will be on the front lines providing geriatric care. IPE is a relatively new concept, but will undoubtedly continue to establish and refine itself as a crucial component of healthcare education. This program should deliver specific geriatric care content to familiarize students with new paradigms to which they will be exposed upon graduation. In light of the ever-increasing demand for geriatric care, IPE as a means of training capable providers may be one of the solutions that Canada’s healthcare system desperately needs.

Michael and Alex are second-year medical students interested in integrative geriatric care. Michael’s research focuses on frailty and critical care outcomes, medical education, and global health. Alex is passionate about prandiatric surgery as well as the improvement of care for those living with dementia and their caregivers.
Innovative Approaches to Engage Older Adults with Technology

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Colin R.J. Whaley, BSc Candidate, Class of 2018, University of Waterloo

Twenty-first century technologies provide numerous benefits to older adults, including increased socialization, well-being, and quality of life (1,2). As technologies such as smartphones and tablets continue to explode in popularity amongst all age groups, factors hindering the adoption of these tools by older individuals serve as barriers, ultimately limiting their use (3). Some of these barriers include income, usability, and perceived user safety (4,5). Appropriate solutions are required to encourage the use of technology among older adults. This commentary provides a summary of select initiatives that seek to improve older adults’ adoption of recreational technologies.

While continued innovations in technology have yielded a proliferation of low-cost devices, (e.g. products in Amazon’s Fire tablet lineup), users’ adoption of technology shows discrete stratification. This disparity, termed the “digital divide,” includes a myriad of socioeconomic factors in its list of contributing factors (6). Despite this, innovations allowing everyone to access the internet exist. For example, in our community, the Kitchener Public Library has started a program allowing library users to borrow internet hotspot devices, allowing access anywhere there is cell signal (7). Internet service providers are also working to get more low-income households online, in some cases by offering home internet plans for more than 75% off (7).

The authors of this commentary co-founded enTECH Computer Club, a student run club at the University of Waterloo that increases technological literacy of residents at long-term care homes by engaging them with technology for recreational purposes such as email and video conferencing. Similar in-person teaching services have been developed across the country, such as Cyber-Seniors. The Gadget Guides, and programs at local libraries (8,9). However, the residents participating in enTECH have stated that there is a relative paucity of such services in their area. Fortunately, tools also exist to assist seniors where such programs are unavailable. Tech-Boomers, for example, is a free website that provides highly comprehensive text and video tutorials to popular apps and websites with a user experience optimized for older adults (10).

The users’ experience of computers differs subjectively as a function of age; this is commonly due to age-related changes and chronic disease that can limit one’s ability for efficient computer interaction (11). To accommodate for these changes, Seals et al. suggests providing simple options on websites like allowing font size and contrast to be modified. Accordingly, some websites and mobile apps (e.g. Big Font) have accommodated for the physical barriers of aging by implementing buttons that can change font size, magnification, and colour inversion (12,13). In addition to physical barriers, older adults may be further dissuaded to use technology due to their self-perceived inexperience with computers, which can easily make them become intimidated by cybersecurity. Operating systems like Chrome OS, which prioritize security allow for users to be more confident that software-based threats like viruses will not damage their machines (14). Retrofitting older computers with Chrome OS is possible through the use of software like CloudReady, which is specifically designed to work well on older systems (15). Optimizing computing environments for older adults requires considerations at both a technological and psychological levels, but can thankfully be accomplished quite readily with free software.

This commentary provides an overview of exciting initiatives that have been developed in order to improve older adult’s adoption of technology. While the efficacy of these interventions have not been studied extensively, older adults are continuing to show significant increases in smartphone and internet usage (3). Despite these improvements, it is important to continuously pursue novel methods to maintain these positive trends. One method of doing so, as stated earlier, is the increased creation of formal tutoring programs across Canada. In addition to this, the decreased expense of technology can lead to volunteer services’ ability to obtain used and refurbished products at a fraction of the original cost. This equipment can then be donated to older adults, thereby further reducing the digital divide. All in all, it is imperative that the ongoing development of initiatives to improve adoption of technology encompasses both social and technological factors. 

References

Expanding Lessons on Caregiving: A Case for Caregiver Experiences in Medical Education

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For most Canadians faced with a health condition, the majority of their day-to-day care is not provided by a health professional, but rather by their family member or friend (1). Even for individuals who receive publicly funded home care services, the support provided by “family caregivers” becomes an integral part of the care plan (1,2).

While caregivers support our formal health system, they often do so at significant personal, social, physical, emotional, and economic costs (3). The cost of not supporting family caregivers will result in greater use of our inpatient health care institutions (3).

Physicians are well-positioned to support family caregivers in sustaining their caregiving role. Moreover, allowing space for caregivers to be present in the consulting room can improve patient and their family members’ experiences within health care systems. However, the formal recognition of family caregivers as a key partner in health care delivery must begin within medical education, so that the next generation of health care providers are in a position to consider, assess, and support caregivers.

To involve caregivers, students should first learn how to informally determine caregivers’ emotional and ongoing support needs just by talking to them. Studies have found that caregivers experience less depression when physicians take the time to listen to their needs and opinions (4). Additionally, we should teach our students about formal caregiver stress assessment tools that can be used to assess the needs of caregivers. Many caregiver stress assessment tools, such as the Caregiver Self-Assessment Questionnaire, can be administered by non-clinical staff or completed by caregivers themselves. Once a caregiver’s needs are assessed, the physician is better positioned to suggest necessary supports. Knowledge of provincial and local caregiver support services should be embedded within the medical curriculum so that physicians can help patients and their caregivers navigate the health care system through appropriate referrals or information on available resources. It should be noted that current models of health care may not allow for the additional time and resources required of physicians to adequately support all caregivers needs, and thus, students should have the knowledge of when they should engage with other health care professionals, such as social workers, to provide additional assistance to caregivers.

They say there are two sides to every story, but students are only learning half of the story on patients from the patient narratives and histories they are often presented with. For medical students to learn the other half of the story, they need to hear the story from family caregivers. We should remind students that they can seek permission from patients to share relevant information with caregivers. Many caregivers even know the patient better than the patient knows themselves, which can provide a rich source of clues for diagnoses. As caregivers provide most of the care for patients, students need to hear about their struggles, so that they can learn to use this information in care planning and implementation. Caregivers’ stories can also help close the gap between human experience and medical theory. Students need to hear from caregivers to understand the human repercussions, on patients and on their loved ones, of the conditions and illnesses they so incisively diagnose. Caregivers’ stories, trials, heartaches, hopes, happiness, and griefs can have a profound impact on the empathy of future physicians.

The practice of medicine requires acting in the best interests of patients. Support from caregivers enables patients to stay at home longer contributing to a higher quality of life for patients and often, to a greater peace of mind for their families (5). In maintaining a patient focus but also acknowledging and including the caregiver in medical education, future physicians can have a positive impact on the caregiving experience. Each caregiver’s situation will be uniquely different, yet completely pertinent to medical trainees, physicians, and patient care.

Kristina Marie Kokorelias is a doctoral student within the Toronto Rehabilitation Institute at the University of Toronto. Her current program of research aims to explore the implications of caring for persons with chronic illness in the community, access to care, and caregiving trajectory to inform the development of timely and relevant programs to support caregivers to sustain their role.

Because of you, we see.

1. Keefe J. Care of elderly persons in Canada: Key issues and policies. A draft background paper prepared for the Canadian Association for Community Living 2003

Before every fruit comes the support of its trunk and branches. A support so strong and so unwavering, just like that which you give us, our mothers, fathers, grandmothers, grandfathers, and friends. This support is the foundation of the life, leading us to knowledge, new heights and light. Because of you we see.
Electroconvulsive Therapy’s 80th Birthday

AMANDA CANFIELD, PGY | PSYCHIATRY
McMaster University

E arlier this year, during my first year as a psychiatry resident, I helped to teach second-year medical students at McMaster University an introduction to the psychiatric interview and mental status exam. During our teaching sessions, I was able to provide the students with an opportunity to interview patients with mental health concerns.

The first patient I took them to interview was an elderly individual with psychotic depression who was receiving electroconvulsive therapy (ECT) treatments. They told the students and me how ECT had essentially saved their life. Prior to their admission to hospital, they described feeling hopeless with no option to relieve their suffering other than taking their own life. Given my early interest in geriatric psychiatry during medical school, I had met multiple elderly patients with similar positive experiences with ECT. Patients who told myself, and the interprofessional teams that I worked with, that ECT had very positively impacted their lives despite many of them initially being quite hesitant to try it. I also objectively saw dramatic changes to their mental status with the treatments.

After the interview, the students told me how pleasantly surprised they were to hear such a positive experience with ECT. I had forgotten how impactful these experiences could be, particularly on any preconceived ideas we have about ECT given its often negative portrayal in the media. During a later psychiatry-teaching block, I was required to do a presentation on any area within the “History of Psychiatry”. My teaching experience motivated me to complete the project on the “History of ECT” as I believe how ECT was developed plays a role in it remaining controversial within society. I hope that this will become clear after I summarize my findings.

The use of electricity in medicine may date back as early as Ancient Rome when electric eels were used for the treatment of migraines and other medical conditions. However, recent literature on the use of electricity for medical purposes starts in the 1700s (1). While many believe that this was the first step in the development of ECT, others argue that electrotherapy is not actually related to it as it was the electric stimulus itself that was thought to have healing properties whereas ECT focuses on the effects of convulsions (1).

Jumping forward to the 1900s, an Austrian psychiatrist named Julius Wagner-Jauregg used a widely accepted observation at the time that febrile episodes improved the symptoms of many other disorders (1,2). Wagner-Jauregg gave intramuscular injections of blood from infected patients with malaria to patients with neurosyphilis, thus being the first known time when febrile episodes improved the psychotic symptoms of individuals with malaria. This was the first known time when the goal of inducing fever and ultimately improving psychotic symptoms was undertaken (1). He began using the induction of convulsions using intramuscular injections of camphor oil in 1934 and later switched to the use of Metrazol as it produced more immediate effects (1).

Ugo Cerletti, a psychiatrist at the University of Rome, was intrigued by Meduna’s theory but postulated that electrically induced convulsions could make the treatment more effective. He worked with a neurologist, Lucino Bini, to trial this idea on dogs (2). They were initially concerned about a previously documented high mortality rate in animal experiments involving electrically inducing seizures (1,2). Bini determined this to be the result of fatal arrhythmias secondary to electrode placement in the mouth and rectum and found no dogs died when he placed both leads on the temples to prevent current from passing through the heart (1,2).

After deeming the safety of ECT acceptable, the first human treatment took place in 1938 on a 40-year-old man with schizophrenia. He had thirteen treatments in total and was discharged home in reportedly good condition. Despite seemingly good outcomes, early ECT was not without side effects. Some of the noted side effects included fractures as a result of muscle spasms, high levels of emotional distress, and cognitive changes (1). ECT has advanced significantly since this time and currently most complications can be avoided or managed. Contemporary use of ECT that includes a pre-ECT assessment, optimization of medical care, involvement of anesthetist, and prompt attention of medical concerns, has allowed it to maintain a very low rate of morbidity and mortality (3). Today, common post-ECT complaints include headache, muscle aches, nausea, and vomiting (3). However, many of the adverse effects of early ECT are displayed in media depictions of modern ECT and this likely contributes to negative views amongst society. It may also have played a role in why many of the patients I have spoken with thus far in my training were worried about adverse effects of ECT that rarely, if ever, occur today.

The year 2018 marks the 80th year since Cerletti and Bini reported their first human ECT treatment. Much has changed during this time in order to improve its efficacy and reduce adverse effects. The Canadian Psychiatric Association continues to recommend that ECT remain an available treatment option for serious mental health disorders including major depressive disorder, bipolar disorder, and schizophrenia (3). Nonetheless, ECT continues to have many negative connotations amongst society at least in part as a result of its history. I hope that medical trainees, like the students I taught in the fall, will have opportunities to interact with patients who have received ECT and/or observe ECT sessions. Hopefully trainees can then disseminate knowledge that ECT, despite challenges during its development, is now a safe and effective treatment that can often provide significant positive effects to appropriate candidates.

Amanda is a first year psychiatry resident at McMaster University as well as the Geriatric Psychiatry Representative for the Resident Geriatric Interest Group. She is an active member of both the Canadian Geriatrics Society and the Canadian Academy of Geriatric Psychiatry. She became interested in caring for older adults while working in a long term care home in high school. She has since developed a passion for promoting awareness of the unique health and social challenges of older adults, as well as fostering interest amongst students and residents in the care of the elderly. Her clinical interests include delirium, late onset depression, and behavioral and psychological symptoms of dementia. She hopes to continue on to complete subspecialty training in geriatric psychiatry.
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Dalhousie University

GIG Execs: Sebastian Copp, Nicole Roda

The Geriatrics Interest Group at Dalhousie is designed to help generate medical student interest in geriatrics as a career choice. Our most important focus is on building professional relationships with our members and with the community. We hold regular meetings with local geriatricians and stakeholders to gain insight into the current state of geriatric medicine in Atlantic Canada. We also organize learning opportunities such as lunch and learn sessions, guest lectures, and visitation to local geriatric facilities. Our goal is to increase awareness of geriatrics as a specialty and encourage students to consider it as a potential career path.

University of Manitoba

GIG Execs: Suhyun Kim, Sophie Quinn

The Geriatric Interest Group of University of Manitoba strives to inform students about the relevance and importance of geriatric medicine in various disciplines. Our hope is to encourage students to consider geriatrics as a valid career option by exposing them to the complexities of aging through workshops, seminars, and networking events. We also aim to strengthen connections with local geriatricians and stakeholders to promote geriatric medicine as a viable career choice.

University of Toronto

GIG Execs: Alexander Addifar, Samantha Yang

The UofT GIG is continuing to provide medical students with networking and educational opportunities in the field of geriatrics, as well as raise awareness about the health and social challenges of older adults. We have had the 2017-2018 academic year with a career panel that brought together professionals in geriatric medicine, psychiatry, emergency medicine, and geriatric medicine. Our mission is to provide educational events and networking opportunities for students, as well as to foster collaboration with other groups interested in geriatrics. We are currently organizing a Geriatricians’ Meet & Greet dinner that will be held in April, where students can meet with UofT residents and geriatricians. In April, we have another “Interests” seminar with Dr. Jenny Basran, the owner of Home Instead Senior Care in Saskatoon. He spoke about the role that physicians can play in homecare options. Recently, Saskatchewan’s only Geriatrician, Dr. Jenny Basran, spoke with members of GIG about a career as a geriatrician and the road to becoming a geriatrician. This insightful talk touched on the clinical and community needs that geriatricians can have in the healthcare field. In the next months, the GIG will be hosting an event with the Alzheimers’ Society of Saskatchewan. This event will include a patient-facilitated support group and a discussion about the different aspects of geriatric care. Students will have the opportunity to meet other students from different disciplines, gain insights about the multidisciplinary aspects of healthcare required to best manage the geriatric population.

University of Saskatchewan

GIG Execs: Nadine Ghazaleh, Bayan Malakouti

The University of Saskatchewan’s (U of S) College of Medicine Geriatric Interest Group (GIG) has had a very exciting year of events, with more events on the horizon. This year the GIG hosted an event with Dr. Lilian Thorpe, a Geriatric Psychiatrist, and her colleagues who spoke about their work with UofT residents and geriatricians. In April, we have another “Geriatrics in Action” seminar with Dr. Jenny Basran, who came in to talk about the role that physicians can play in homecare options. Recently, Saskatchewan’s only Geriatrician, Dr. Jenny Basran, spoke with members of GIG about a career as a geriatrician and the road to becoming a geriatrician. This insightful talk touched on the clinical and community needs that geriatricians can have in the healthcare field. In the next months, the GIG will be hosting an event with the Alzheimers’ Society of Saskatchewan. This event will include a patient-facilitated support group and a discussion about the different aspects of geriatric care. Students will have the opportunity to meet other students from different disciplines, gain insights about the multidisciplinary aspects of healthcare required to best manage the geriatric population.

Western University

GIG Execs: Priya Khoral, Joy Sun

Our vision is to educate students on medical issues specific to aging, with the ultimate goal of increasing awareness about aging and the need for better care for older adults. The Geriatrics Interest Group at Western is a student-led group that aims to educate medical students on geriatric medicine as a specialty, but also to improve the care for older adults across Canada. As a student-led group, we aim to build awareness of geriatric medicine and encourage students to consider it as a potential career path. We also strive to build relationships with local geriatricians and stakeholders to promote geriatric medicine as a viable career choice.

University of Ottawa

GIG Execs: Yi-peng Ge, Aleena Fiorotto, Francine Heelan

Our vision is to engage medical students with the health concerns of our geriatric population in Canada specifically by exposing them to the complexities of geriatric medicine, some of the issues and learning how to better care for patients with dementia. Our events for this winter semester include a discussion on medical assisted dying in which we will discuss the legislation, practical experience of 3 physicians, and the opportunity to propose the service. Our second event will be hosted with the Alzheimers’ Society of Ontario wherein a caregiver will speak about the different aspects of patient care. Students will have the opportunity to meet other students from different disciplines, gain insights about the multidisciplinary aspects of healthcare required to best manage the geriatric population.
Interview with Dr. Don Melady

Dr. Don Melady is an Emergency Physician at Mount Sinai Hospital in Toronto. He focuses his academic and educational activities on Geriatric Emergency Medicine and on quality improvement to create senior-friendly Emergency departments. Follow him at @geri_EM. Visit www.geri-EM.com

How did you develop an interest in Geriatric Emergency Medicine?

I am a career Emergency physician, completing 30 years of work as an Emergency doctor, and I have always had a special interest in older people. This goes back to my upbringing – I grew up around a lot of older people. At one point I had 32 aunts and uncles over the age of 75! I’ve always felt comfortable around older people. It’s not that I think many people are, to find about 10 years ago that there is a need to headline their care. This is really what we do in Emergency department. We need to keep members as they try to navigate their way through a crisis. This is what I call being geriatric medicine.

What changes are being made to the medical school and residency programs in Canada to educate trainees about Geriatric Emergency Medicine?

Yes, I think it is a change from 10-15 years ago. I have taught the [Senior-Friendly ED] course four times and on each occasion, we have needed to turn away hospital teams because we didn’t have enough space. So I think hospitals are starting to get interested.

Interviews

Bringing Geriatric Medicine to the Emergency Department: Geriatric EM

Interview with Dr. Don Melady

BONNIE CHEUNG, MD CANDIDATE, CLASS OF 2018
UNIVERSITY OF TORONTO

Bonnie Cheung is a fourth year medical student at University of Toronto. Her interests in geriatrics developed while volunteering for the Hospital Elder Life Program, a patient-care program that prevents delirium. She has done research in neuroimaging in elderly patients with cognitive impairment and depression as well as the use of Twitter in geriatric medical education.

Bringing Geriatric Medicine to the Emergency Department: Geriatric EM

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Since Bill C-14 passed on June 17, 2016, more than two thousand people have taken advantage of medically assisted death in Canada. In fact, there was a 46.1% rise in completed Medical Assistance in Dying (MAID) as compared to the numbers in the first six months that the legislation was in place, now comprising of approximately 1% of all deaths nationwide (1). It comes to no surprise that the average age of individuals who were provided with medical assistance in dying was 73, with the majority falling under the geriatric age group of 65+ (1). Regardless of our ethical stance, we are facing a future where our aging population will require assistance with discussions on MAID, but how much do we really know?

British Columbia has led the country in medically assisted death, likely due to multiple factors including demographics, accessibility, and a long history of advocacy. I decided to interview Dr. Janet Kushner-Kow, Clinical Associate Professor and UBC Division Head of Geriatric Medicine, to understand how MAID has impacted the practice of geriatric medicine.

What are your experiences with patients who request MAID?

We have a lot of requests in the lower mainland. I think it’s cultural and whether that will shift. I don’t know. Most of the patients know that it’s an option and a lot of them feel that they are happy to have that option even if they don’t go through with the assessment. I think it’s because patients in B.C. want to take control of what’s going to happen to them. Some patients want to have a say in how and when they are going to die. I’ve heard patients say: “I want [my family] holding my hand.” “I want to be awake and then gone, not this slow process where they see me dying.”

I was present for a patient who went through with MAID. He was quite frail. His family was there and it happened very quickly. You’re surprised when you’re watching. The first vial went in and he was quite frail. His family was there and it happened very quickly. You’re surprised when you’re watching. The first vial went in and he was weak and could not get out of bed. He said he had done everything he needed to do and all he was doing was waiting to die. Although he enjoyed being with his partner, there was nothing left for him. There wasn’t a lot of physical suffering. “Being here is making me feel uncomfortable not because I’m in pain. Not because I’m short of breath.” “I’m not meant to be here anymore.” “I’m done.” It was an existential suffering. Psychiatric illnesses and advanced directives are now in an area of contention that will likely be brought to the Supreme Court.

Access has been an issue that is being addressed in the media due to lack of information among the public and medical professionals. In fact, there have been concerns that many Canadians have died while waiting for an assisted dying that is not a result of outside pressure or influence. What infrastructure is in place to ensure patients are informed and have timely access to MAID, even in faith-based institutions?

For each assisted death, there are likely many more patients who are ineligible, with the most cited reasons being lack of mental competency and the fact that death is not foreseeable (1). What role does MAID play in a patient with dementia?

You can still have MAID even if you have mild dementia as long as you are still capable. You need to know and understand your options, including palliative care. There have been eligible patients, who have dementia and part of why they want to die is because they didn’t want their disease to progress. Some have intolerable suffering while others have been burned down. It might be hard to imagine, but you can want to die and not be clinically depressed. These people are not depressed. They still find joy in life. They have a subjective reason to die. I did speak to one fellow in palliative care where pain was taken care of, but he was weak and could not get out of bed. He said he had done everything he needed to do and all he was doing was waiting to die. Although he enjoyed being with his partner, there was nothing left for him. There wasn’t a lot of physical suffering. “Being here is making me feel uncomfortable not because I’m in pain. Not because I’m short of breath.” “I’m not meant to be here anymore.” “I’m done.” It was an existential suffering. Psychiatric illnesses and advanced directives are now in an area of contention that will likely be brought to the Supreme Court.

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It will just take time. There is not a clear understanding of what the process is and who is eligible, so there’s still an issue. Health Canada has a team. Most health care professionals know the resources. When a patient requests MAID at a faith-based institution, it goes to the regional team. If they are too far to travel, then they can get special dispensation to get assessed on special circumstances due to “undue hardship.” If you want to have the procedure, it would need to be at another site. In addition to the two large faith-based hospitals in the lower mainland, there are also faith-based associated nursing homes and a hospital. They are not allowed to have MAID at home. It’s going to be tough in terms of who’s going to do it and where they are going to do it. The logistics will be tricky with many cases. You are allowed to use telehealth to do assessments, but a physician or NP has to be there for the procedure. This issue will probably be brought to the Supreme Court.

You do have any final words on how MAID has changed end of life care?

I tell people that between cannabis and MAID, it’s changed elder care significantly. Many people are functionally impaired and they are dependent on the medical system, but want help. Pain is so difficult to treat that we need these options. It has really opened up the discussion of death. In fact, it is now integral to the whole discussion of end of life, especially in palliative care. It’s too early to say that’s what we see here, but anecdotally, it makes the discussion easier. MAID is going to be new for frailty, especially in B.C., where so many people are interested. End of life is getting very complex and geriatrics are in the forefront of this. There’s no black and white. Everyone’s story is different, family dynamics around death is enormously complex, and then you throw in psychiatric disorders. It’s fascinating.

This is currently a fourth-year medical student at UBC. She serves as the VP External of the National Geriatrics Interest Group. Her experiences with geriatrics have been overwhelmingly positive, and she looks forward to sharing her experiences.


Interview with Dr. Janet Kushner-Kow

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Eligibility for MAID is as follows (2):

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<tr>
<th>Experience unbearable physical or mental suffering from your illness, disease, disability or state of decline that cannot be relieved under conditions that you consider acceptable</th>
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<tbody>
<tr>
<td>Be eligible for health services funded by the federal government, or province or territory</td>
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<tr>
<td>Have a grievous and irremediable medical condition</td>
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<td>Make a voluntary request for medical assistance in dying that is not a result of outside pressure or influence</td>
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<tr>
<td>Be at least 18 years old and mentally competent</td>
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<tr>
<td>Be in an advanced state of decline that cannot be reversed</td>
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<tr>
<td>Have a serious illness, disease or disability</td>
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<td>Give informed consent to receive medical assistance in dying</td>
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Notes:

1. Experience unbearable physical or mental suffering from your illness, disease, disability or state of decline that cannot be relieved under conditions that you consider acceptable
2. Be eligible for health services funded by the federal government, or province or territory
3. Have a grievous and irremediable medical condition
4. Make a voluntary request for medical assistance in dying that is not a result of outside pressure or influence
5. Be at least 18 years old and mentally competent
6. Be in an advanced state of decline that cannot be reversed
7. Have a serious illness, disease or disability
8. Give informed consent to receive medical assistance in dying

Code of Ethics for Medical Assistance in Dying:

- Be at a point where your natural death has become reasonably foreseeable
- Experience unbearable physical or mental suffering from your illness, disease, disability or state of decline that cannot be relieved under conditions that you consider acceptable
- Be eligible for health services funded by the federal government, or province or territory
- Have a grievous and irremediable medical condition
- Make a voluntary request for medical assistance in dying that is not a result of outside pressure or influence
- Be at least 18 years old and mentally competent
- Be in an advanced state of decline that cannot be reversed
- Have a serious illness, disease or disability
- Give informed consent to receive medical assistance in dying
Geriatric Inclusive Art as a Promoter of Wellbeing: A Pilot Program

KACPER NIBURSKI, MA, MD CANDIDATE, CLASS OF 2021, MCGILL UNIVERSITY
APPROVED BY: DR. OLIVER BEAUCHET, DEPARTMENT OF GERIATRIC MEDICINE, MCGILL UNIVERSITY
REVIEVED BY: UYEN DOAN, MD, PGY5 GERIATRIC MEDICINE, MCGILL UNIVERSITY
KACPER NIBURSKI, MA, MD CANDIDATE, CLASS OF 2021, MCGILL UNIVERSITY
APPROVED BY: DR. OLIVER BEAUCHET, DEPARTMENT OF GERIATRIC MEDICINE, MCGILL UNIVERSITY

The configuration of hospitals is largely predicated by acute care management. Multiple comorbidities and associated chronic symptoms of illness are often left either unconsidered, masked, or too overtly difficult to deal within the scheme of management-based care (1). These problems of immediate interventions are only exacerbated in geriatrics, where the constellation of disease states come into constant interaction with a patient’s wellbeing. Due to their multifaceted, interacting illnesses, hospitalized older adults often suffer from a higher disease burden (2), express greater dissatisfaction in care received (3), and draw a conclusion on the effects of the study. on the other hand, the anecdotal evidence is abundant. Numerous patients have reported a sense of accomplishment at producing artwork again, at having it displayed on the ward, at being able to make a mark on the world, and doing work in relation to and with others in the ward. This type of emotional wellbeing as a result of community interaction has been well documented in a number of studies (4). Familiarity with the patient’s sense of accomplishment in these various domains has also not felt comfortable painting, and prefer other modes of recreation or decreasing the patients’ length of stay.

Such situations are a further challenge in cases of dementia. According to this recent study found that 42% of patients over the age of 70 had dementia, with that number expected to climb in the coming years (3). While care in patients with dementia is similar to general geriatric patients, the progressive cognitive decline poses a long-term difficulty. Studies have determined that patients with dementia experience worse health outcomes than general patients (6), longer lengths of stay (7), and complications from their disease (8).

The reasons for these results have not been fully elucidated, though some speculation exists. Emotional stability has been discovered as an important factor in determining disease progression. Antidepressants which promote positive emotion during hospitalization delay negative health outcomes while buffering positive ones (14). Critical theory proves useful in helping digger to this mechanism; emotional maturation is central to the discourse of fields like narrative medicine. At its core is the suggestion that a disordered disease is often configured into an ordered storyline. In particular, disease is based on “temporality, accountability, intersubjectivity, and ethicality” (15). Each patient is at the intersection of each of these aspects of disease, and the way patients comprehend their disease affects not only how they understand their diseases but also the entirety of their health.

Art therapy hinges on this narratology and bears witness to the disease through one’s own perspective. The act of creation is inherently personal, allowing an intimacy with the materials. The piece becomes a coherent form, and in manipulating and manifesting art from arbitrary means, the patient can relive, realize, and recontextualize how to produce meaning to disease. They are in control. They internalize their story. They honour their continuity against its projection.

Despite this theory and previous research, no study has directly linked art therapy and its associated theory to cognitive decline (16). Nor has a study looked explicitly at health outcomes and how to mitigate art therapy in geriatric medicine. Currently at the Jewish General Hospital in Montreal, we have worked on specializing art therapy for geriatric populations, a process entitled Geriatric Inclusive Art (GIA). Patients over the age of 65 are offered painting sessions where they can produce art with any array of four colours on a small canvas. They are guided by Dr. Olivier Beauchet. The research collects a variety of touchpoint points based on a Likert scale, such as whether anxiety was caused or diminished with the participating in the painting. After these coded themes are compiled against hospital records to see if there was an improvement in neuropsychological outcomes such as anxiety, communication, behavioral disturbances. The final aim was to determine if GIA painting sessions can decrease the incidence of adverse outcomes such as falls, lessening the prescribed number of psychotropic medications or decreasing the patients’ length of stay.

GIA has proven effective in other smaller programs already. Emerging as a result, we have identified the potential to improve emotional well-being and has been hypothesized to directly reduce morbidity and mortality. A 3-month pilot project has been conducted in which we attempted to determine project feasibility, which was followed by the scaled project itself. The latter is currently still ongoing in 2018, and so it too early to assess and conclude anything about the outcomes of the study. On the other hand, the anecdotal evidence is abundant. Numerous patients have reported a sense of accomplishment at producing artwork again, at having it displayed on the ward, at being able to make a mark on the world, and doing work in relation to and with others in the ward. This type of emotional well-being as a result of community interaction has been well documented in a number of studies (4). Familiarity with the patient’s sense of accomplishment in these various domains has also not felt comfortable painting, and prefer other modes of recreation or decreasing the patients’ length of stay.

Moreover, these qualitative metrics have been preceded by similar pilots of the program. A study in France showed that GIA initiatives reduced hospital lengths of stay and in-hospital mortality (17). However, it was noted that further, larger studies needed to be done to quantify the actualization that patients feel in their own work.

Some limitations of the study will present themselves. The trial is an open-label trial, therefore a non-randomized design, and the number of GIA sessions per participant has been variable, based on the size of the ward and patient’s ability. Art therapy for geriatrics has been limited by a small sample size, as obtaining consent, either from capable patients or families, has been difficult. Furthermore, some patients also do not feel comfortable painting, and prefer other modes of creative endeavors.

Yet despite this, the results are encouraging in the current climate of hospital care. This is especially true given the increasing efforts to diminish illness exacerbation in geriatric patients and limited pharmacological treatments for BPSD. If hospitalizations can be reduced, health outcomes can be maximized, and if health can be more sustained and stable in an inexpensive way, the ability to preserve patient’s sense of self and daily activities through GIA will become a key aspect in geriatric care management.

The Geriatric Inclusive Art team at the Jewish General Hospital is a group of researchers and art therapists who believe in alternate possibilities to care pathways. By focusing on developing health through emotional wellbeing and community, the team is hoping GIA will prove efficacious in decreasing health burdens in geriatric populations.

References:
13. Sauer PE, Fopma-loy J, Kinney JM, lokon E. “It makes me feel like myself”: Per-ception or decreasing the patients’ length of stay.
14. Nor has a study looked explicitly at health outcomes and how to mitigate art therapy in geriatric medicine. Currently at the Jewish General Hospital in Montreal, we have worked on specializing art therapy for geriatric populations, a process entitled Geriatric Inclusive Art (GIA). Patients over the age of 65 are offered painting sessions where they can produce art with any array of four colours on a small canvas. They are guided by Dr. Olivier Beauchet. The research collects a variety of touchpoint points based on a Likert scale, such as whether anxiety was caused or diminished with the participating in the painting. After these coded themes are compiled against hospital records to see if there was an improvement in neuropsychological outcomes such as anxiety, communication, behavioral disturbances. The final aim was to determine if GIA painting sessions can decrease the incidence of adverse outcomes such as falls, lessening the prescribed number of psychotropic medications or decreasing the patients’ length of stay.
We had the privilege of visiting a palliative care patient back in first year of medical school. Despite their pain, he and his family graciously allowed us to enter into their lives, which for this time resided in a little room with two beds - one was a patient bed and the other was a couch made into a bed so that the wife did not have to leave the husband.

The four loved ones really helped maintain the person that the man was - they kept his humour, strength, swagger, and reminded us of his love for electronic gadgets and music. Even more so though, the man was highlighting the people his loved ones are, and was probably playing a role in molding who they were becoming: a devoted wife who was the sunshine in the room and who smiled through everything, a protective cousin who was strong but at moments was reduced to weeping, a nonchalant aunt and uncle whose poise maintained the calm through the storm.

It's all too easy to reduce people to cases and numbers; let's hope we'll not forget the intricate web of relationships built around each person and the spectrum of their needs requiring loving attention.

Camilla is a third-year medical student at McGill University. Born in China, raised in England and educated in Singapore, she came to Montreal to complete an Bachelor of Science with Honours in Anatomy and Cell Biology. Working with local communities in this city cultivated in her a desire to use her skills to serve the underserved. Outside of being a student, she enjoys dabbling in piano and painting. She draws inspiration for her art from personal experiences in hopes of capturing evanescent moments of the day-to-day.

Maggie is a recent BScN graduate from McGill University and a native of South Surrey/White Rock, BC. She currently works as a community health nurse and home care nursing supervisor in a northern Indigenous community. Upon her high school graduation, she received a arts scholarship to further the development of arts in her local community. With such encouragement, she continued creating artworks while pursuing her passion in nursing at McGill. Maggie has a special interest in generative and global health and loves being in nature. Hence, her creations are based on the theme of nature, which for her, symbolizes health, hope, life, and a place to relax the mind.
Veterans Through a New Lens

IULIA POVIERIENA, MD CANDIDATE, CLASS OF 2018, UNIVERSITY OF OTTAWA

A bright April morning started with a fresh gust of wind as a reminder that the winter had not quite let go yet. After walking in a few circles on the residential streets searching for the right building, I finally found the main entrance. The building itself resembled a small town with streets, shops and all the services inside. It was 8-45 am and the doors were empty and quiet with no one to guide me to my ward.

I had reported to the nursing station at 9 am where I met my attending, Dr. G. She was just about to go to a family conference meeting for one resident, Mr. P: a 101-year-old veteran with moderate dementia, urinary incontinence, and congestive heart failure. Dr. G gave me 5 minutes to review his chart. I knew what the team was talking about and then we went to a conference room.

A team of healthcare providers was already waiting for us. There was a nurse, a pharmacist, a social worker and a dietician. The patient’s daughter was on the teleconference call because she was having a nightmare for many internists. In a time when baby boomers have begun to flock geriatrics wards, this “problem” is on everyone’s agenda. To professionals, aging is frequently associated with images of frail individuals, abandoned by family, hooked up to IVs and ventilators, clinging to life. It is no surprise; then, that people grow apprehensive of reaching this state.

When the young fear aging, it creates multiple problems. Firstly, elders grow increasingly isolated. It is only natural that we avoid what we fear. Secondly, it leads to psychological turmoil when a formerly “young” person begins to feel the effects of aging on their bodies. How can one consolidate well-engrained negative perceptions of seniors with their newfound categorization into this social class? This cognitive dissonance inevitably leads to tremendous stress. In summary, this system of thoughts is detrimental to entire societies and must be eliminated. The question is—how?

One simple intervention I have found incredibly helpful for myself is to welcome rather than avoid thoughts of aging. I constantly entertain the notion of growing old and allow this reality to underlie many of the decisions I make on a daily basis. What will matter most at the end of my life? How can I best tailor my career, which is now in its infancy, to address these overarching goals? Another way I have managed to mitigate negativity surrounding aging is by spending time with older folks who are living healthy, happy lives. Aging does not need to co-exist with disease and misery. Many older individuals are so positive and have valuable perspectives to share. This contrariness is mutually beneficial for myself and elders who often seek company.

Growing old is a process that individuals and entire societies continue to grapple with. However, instead of being viewed as a problem, it should be embraced as a beautiful, natural phenomenon that can inform how to best live our lives from an early age. Growing old is not a process I no longer fear; it has become a central tenant of my life.

Thanhthao is currently a daughter, sister, friend, amateur artist, writer and 3rd year medical student at the University of Ottawa.

On Growing Old

THANHSHKA THANGARASA, MD CANDIDATE,
CLASS OF 2019, UNIVERSITY OF OTTAWA

It was not always like this. In previous eras, elders were viewed with respect and were often consulted for their wisdom. In the age of rapid technological expansion, Google has replaced age-associated insight, and it is often the young who are consulted for help with navigating this new cyber-world.

Medical professionals are unique in that their careers often mandate them to have constant exposure to individuals in the terminal phases of their lives. Hospital wards are crawling with older patients riddled with medical comorbidities, lengthy medication lists and complex social situations. They can be medicalmanagement nightmarers for many internists. In a time when baby boomers have begun to flock geriatrics wards, this “problem” is on everyone’s agenda. To professionals, aging is frequently associated with images of frail individuals, abandoned by family, hooked up to IVs and ventilators, clinging to life. It is no surprise; then, that people grow apprehensive of reaching this state.

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Tharshika is currently a daughter, sister, friend, amateur artist, writer and 3rd year medical student at the University of Ottawa.

Sean Cai, PGY-I Internal Medicine, University of Toronto
“He’s confused and hallucinating, he pulled out his IV line and catheter overnight. He was agitated, and security was called. He’s now in restraints...”...

As a fourth year subspecialty resident in geriatrics, this is a common story to be hearing over the phone. Only this time it was my mother calling from the hospital, describing the hyperactive delirium my grandfather was experiencing during his admission for a heart failure exacerbation.

I pride myself on being knowledgeable about delirium. I know the staggering statistics on its frequency in older inpatients. I know the DSM V criteria for its diagnosis. I can’t even count the number of times I’ve taught medical students and junior residents how to identify delirium and its long list of possible triggers. I have talked to dozens of families, educating them about the sudden change they were seeing, and trying to reassure them.

However, when it’s one of your own loved ones, knowledge does not help and the reassurances fall flat. Seeing my grandfather, the stoic farmer, be changed into someone full of fear and accusations was shattering and I was fortunate enough to understand he was in a state of delirium - it was the delirium talking. Imagine what the experience would be like if you were not being educated had not been educated on the diagnosis, which is too often the case.

When speaking to my mother, none of the health care team had used the word delirium. No one had tried to explain the definition and what it can entail, particularly that agitation can be seen, and fluctuations are common. No one had described the typical course of delirium, or had discussed its prognosis.

Families often perceive a severe delirium as the nearing of death. Now I understand why in that moment, when your family member is unrecognizable, it feels like the end. Even more horrifyingly, it feels like the delirium is worse than death itself. Seeing your loved one pull at their restraints brings a heartbreak that cannot be expressed. Hearing health care professionals scold them patients for actions they have no control over, is incredibly difficult.

For the second annual World Delirium Awareness Day (#WDAD2018) people are being asked to become “Delirium Superheroes”. This includes committing to use the term delirium, educating other health care professionals, and listening to patient and family stories about the experience of delirium. Now, more than ever I want to encourage readers to become actively involved in increasing delirium awareness in their own workplace. A better understanding of delirium will not erase the fear that a family experiences, but using the appropriate terms and educating the entire health care team and patients’ loved ones will build a safer and more compassionate environment for the treatment of delirium. I know my grandfather would have benefited from being surrounded by more Delirium Superheroes!  

Alishya Burrell, PGY-4 Geriatric Medicine
Schulich School of Medicine & Dentistry
Wanted: Delirium Superheroes

Alishya is a Geriatric Medicine subspecialty resident in London, Ontario. She completed her Core Internal Medicine training at Western. She is one of the VPs of Social Media for the Resident Geriatric Interest Group, keeping the group active on Twitter and she is also on the planning committee for World Delirium Awareness Day in London.

As a fourth year subspecialty resident in geriatrics, this is a common story to be hearing over the phone. Only this time it was my mother calling from the hospital, describing the hyperactive delirium my grandfather was experiencing during his admission for a heart failure exacerbation.

I pride myself on being knowledgeable about delirium. I know the staggering statistics on its frequency in older inpatients. I know the DSM V criteria for its diagnosis. I can’t even count the number of times I’ve taught medical students and junior residents how to identify delirium and the its long list of possible triggers. I have talked to dozens of families, educating them about the sudden change they were seeing, and trying to reassure them.

However, when it’s one of your own loved ones, knowledge does not help and the reassurances fall flat. Seeing my grandfather, the stoic farmer, be changed into someone full of fear and accusations was shattering and I was fortunate enough to understand he was in a state of delirium - it was the delirium talking. Imagine what the experience would be like if you were not being educated had not been educated on the diagnosis, which is too often the case.

When speaking to my mother, none of the health care team had used the word delirium. No one had tried to explain the definition and what it can entail, particularly that agitation can be seen, and fluctuations are common. No one had described the typical course of delirium, or had discussed its prognosis.

Families often perceive a severe delirium as the nearing of death. Now I understand why in that moment, when your family member is unrecognizable, it feels like the end. Even more horrifyingly, it feels like the delirium is worse than death itself. Seeing your loved one pull at their restraints brings a heartbreak that cannot be expressed. Hearing health care professionals scold them patients for actions they have no control over, is incredibly difficult.

For the second annual World Delirium Awareness Day (#WDAD2018) people are being asked to become “Delirium Superheroes”. This includes committing to use the term delirium, educating other health care professionals, and listening to patient and family stories about the experience of delirium. Now, more than ever I want to encourage readers to become actively involved in increasing delirium awareness in their own workplace. A better understanding of delirium will not erase the fear that a family experiences, but using the appropriate terms and educating the entire health care team and patients’ loved ones will build a safer and more compassionate environment for the treatment of delirium. I know my grandfather would have benefited from being surrounded by more Delirium Superheroes!  

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Sponsors and Special Thanks

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Department of Medicine
McMaster University

Erin Young
Administrative Assistant for Dr. Tricia Woo

The NGIG would like to warmly thank the CGS for their ongoing support of our local and national initiatives.

We encourage all physicians with an interest in geriatrics and other allied health care professionals, medical students, residents, and fellows to join the Society. We also invite researchers in the field of aging to join our organization.

Membership Criteria:
1) Regular — $325.00 per year (Open to all Health Professionals licensed to practice in Canada)
2) Associate — $50.00 (Open to Full-Time Residents/Fellows, Including MSc and PhD students)
3) Students — No Charge (Open to Full-Time Undergraduate Medical and Health Professional Students)

Benefits of Membership:
The annual membership fee of $325 provides members access to the following services:
1. Updates from 2 CGS journals: Canadian Geriatric Journal (Research) and Continuing Medical Education Journal.
2. Involvement in advocacy to improve seniors care
3. Professional secretariat office
4. Reduced rate to attend the Annual General meeting
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